Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	19 October 2021
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Royal College of Physicians Medical Records Keeping Standards (Reasonable Assurance) Update
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Dr Philip Kloer, Medical Director and Deputy Chief Executive
SWYDDOG ADRODD: **REPORTING OFFICER:**	John Evans, Assistant Director, Medical Directorate Lisa Davies, Head of Effective Clinical Practice and Quality Improvement (Medical Directorate)

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Internal Audit Royal College of Physicians (RCP) Medical Record Standards report was first brought to the Audit and Risk Assurance Committee (ARAC) in December 2018 for discussion, with updates on progress with the report recommendations provided to ARAC in October 2019, April 2020 and October 2020.

This report constitutes a further update on progress, as requested at the ARAC meeting held in October 2020.

Cefndir / Background

During discussion at the ARAC meeting in October 2019, assurance was sought on the audit report recommendations and a number of actions were proposed. It was acknowledged at the ARAC meeting in April 2020 that progress with the actions agreed had been hampered due to the deployment of key staff to focus on the COVID-19 pandemic response. However, by the October 2020 ARAC meeting, some good progress was demonstrated, in spite of the ongoing pandemic response.

Actions agreed to progress this area relate to:

- Yearly audit by Specialty
- Structure for reporting Audit Outcomes
- Update to the Clinical Record Keeping Policy
- Provisions for exploring a digitalised system in future
- Development of an e-learning module – Good Record Keeping Practice for Clinicians – RCP Standards
- Stamps

Working arrangements have yet to fully return to normal, however progress continues to be made in relation to the actions wherever possible.

National / local objectives involved

- RCP Standards for Clinical Record Keeping
- Health & Care Standards –3.1 Effective Care
- Health & Care Standards – 3.5 Record Keeping
- Health & Care Standards – 4.2 Patient Information
- UHB Strategic Objectives:
    1. Putting people at the heart of everything we do
    2. Working together to be the best we can be
    3. Striving to deliver and develop excellent services
    4. The best health and wellbeing for our individuals, families and communities
    5. Safe sustainable, accessible and kind care
    6. Sustainable use of resources

Asesiad / Assessment

An update on progress in relation to each of the action areas is noted below. Progress has inevitably been slower than anticipated during 2021 due to the ongoing impact of the pandemic, and a certain amount of adaptation has been necessary to ensure momentum is maintained.

Specific actions will continue to progress, however, it is anticipated that it will take time to see the cultural change, within the context of the restrictions of the pandemic and changes to ways of working.

A meeting of the Record Keeping Audit Working Group took place on 27th October 2020 to discuss suitable next steps. The Group recognised the importance of emphasising professional responsibility and ownership in relation to record keeping, and the human factors associated with this.

It was proposed that following the completion of the audit at Withybush General Hospital, a baseline audit would be undertaken at the other three acute hospital sites. The purpose of this audit was to inform local action plans at site level, based on the findings of each audit. This would enable practice and culture to be addressed at a local level. Once the local baseline has been identified, the Quality Improvement (QI) Site Lead and the Quality Improvement and Service Transformation Team would support the hospital management team in addressing local challenges and drive forward improvement.

As well as identifying the need for a collaborative quality improvement approach at site level, the Record Keeping Audit Working Group discussed other key actions, which were not covered in the previous update, namely:

- Continuing Professional Development (CPD) record-keeping training course – please see the update below, provided under Development of an e-learning module – Good Record Keeping Practice for Clinicians – RCP Standards
- Non-medical staff who contribute to health records will need to be considered – please see the update below, under Update to the Clinical Record Keeping Policy
- Exploring links to revalidation and appraisal, by designating it a Quality Improvement activity for doctors to use at appraisal – following discussion it was concluded that whilst it is not possible to specify as a specific element of appraisal and revalidation, improvements in record keeping can be promoted as a potential quality improvement activity. There is potential to communicate this using the Medical Director's Newsletter.

A more detailed update on the aspects reported in the previous paper is included below.

Yearly audit by Specialty

There is ongoing commitment for the audit to be part of the forward programme on an annual basis, and this will be reviewed under the standing Agenda item at the Clinical Audit Scrutiny Panel. However, the planned yearly audit by Specialty has had to be adapted in response to the constraints caused by the pandemic.

As outlined above, it was proposed that baseline audits would be undertaken under the leadership of the QI Site Leads. The baseline audits have taken place in Bronglais General, Glangwili General Hospital and Prince Philip Hospital during 2021. The audits did, however, take longer to complete and were more complicated due to the impact of the second wave of the pandemic. In recognition of the challenges in terms of access to wards and medical records, it was agreed that the audit would need to be adapted on each site. Therefore, the audits were prospective (rather than retrospective as per previous audits) and involved 10 sets of records from each hospital ward for Bronglais and Prince Philip Hospitals, and 10 sets of records per specialty for Glangwili Hospital, owing to the complexity of accessing the larger number of wards on this site.

It is therefore not possible to collate the findings and compare across the Health Board. However, this was accepted given that the purpose of the audits was to establish a baseline on each site, and for the findings to inform local action plans and quality improvement activity. These are presented below under headings for each site. On the basis of the audit findings, each QI Site Lead has been asked to work alongside their local Quality Improvement and Service Transformation Team to develop a localised action plan to implement plans for improvement. A summary of the audit result is attached at Appendix 1.

Any identified opportunities to progress actions at Health Board level are also outlined below.

Bronglais General Hospital

The baseline audit involved 60 sets of records and it was a prospective audit. 10 sets of records were audited from six hospital wards.

From a review of the findings, the following areas for improvement at Bronglais General Hospital were identified:

Standard 2: Every page in the medical record should include the patient's name, identification number (NHS number) and location in the hospital	Continues to show poor compliance
Standard 3: *Compliance with standardised structure of the health record, following organisational protocol*	Wide variation between wards. It is therefore possible that the question was poorly understood
Standard 5: Data recorded or communicated on admission, handover and discharge should be recorded using a standardised proforma	Two out of six wards did not use a standardised proforma
Standard 8: Every entry in medical record should identify the most senior healthcare professional present (who is responsible for decision making) at the time the entry is made	Compliance of 72% is poor

Standard 6: Every entry in the medical record should be dated, timed (24 hour clock), legible and signed by the person making the entry. The name and designation of the person making the entry should be legibly printed against their signature. Deletions and alterations should be countersigned, dated and timed	Very low number met three standards of date time and countersigning therefore significant improvement needed
Standard 10: Gaps between entries	Patient might have been reviewed but not documented. The Protocol needs clarity and appreciate difference between Acute and long stay admission, what is the maximum acceptable gap in entry.
Standard 12: Advanced Decisions to Refuse Treatment, Consent, Cardio-Pulmonary Resuscitation decisions must be clearly recorded in the medical record. In circumstances where the patient is not the decision maker, that person should be identified e.g. Lasting Power of Attorney	Lots of awareness and improvement is required for all staff; possible area for inclusion in doctor's induction

Areas for improvement are highlighted in the audit report. Local recommendations include:

- Discuss findings with Hospital Director and agree a short-term local action plan to address identified improvements required
- Discuss with Head of Nursing regarding ward variations
- Present at next Whole Hospital Audit Meeting
- Identifying differences across wards and targeting improvement activity accordingly
- Identifying whole-hospital trends
- Awareness raising of good record keeping at ward level/specialty.

<u>Prince Philip Hospital</u>

The baseline audit involved 80 sets of records and it was a prospective audit. 10 sets of records were audited from eight hospital wards.

From a review of the findings, the following areas for improvement at Prince Philip Hospital were identified:

Standard 2: Every page in the medical record should include the patient's name, identification number (NHS number) and location in the hospital	Continues to show poor compliance
Standard 3: *Compliance with standardised structure of the health record, following organisational protocol*	Though overall compliance is low, some wards reported 100% compliance and others 0% compliance. It is therefore possible that the question was poorly understood
Standard 5: Data recorded or communicated on admission, handover and discharge should be recorded using a standardised proforma	Only one ward documented using a standardised admission proforma. Regarding discharge proforma despite low compliance documented all wards use the electronic discharge summary (DAL) so it

	is therefore likely that the question was poorly understood
Standard 8: Every entry in medical record should identify the most senior healthcare professional present (who is responsible for decision making) at the time the entry is made	Improvement is required
Standard 6: Every entry in the medical record should be dated, timed (24 hour clock), legible and signed by the person making the entry. The name and designation of the person making the entry should be legibly printed against their signature. Deletions and alterations should be countersigned, dated and timed	Compliance with date time and signature were good. Compliance with standards regarding deletions/alterations made was generally low
Standard 10: An entry should be made in the medical record whenever a patient is seen by a doctor. When there is no entry in the hospital record for more than four (4) days for acute medical care or seven (7) days for long-stay continuing care, the next entry should explain why	Further investigation is required to review the wards reporting that they did not have a protocol for time period gap reporting. These wards reported a 'not applicable' response, which impacts on ability to meet the Standard
Standard 12: Advanced Decisions to Refuse Treatment, Consent, Cardio-Pulmonary Resuscitation decisions must be clearly recorded in the medical record. In circumstances where the patient is not the decision maker, that person should be identified e.g. Lasting Power of Attorney	Improvement is required

The following site level improvement actions have been planned:

- Discuss findings with Hospital Director and agree short term local action plan to address identified improvements required
- Present at next the next Whole Hospital Audit Meeting
- Identifying differences across wards and targeting improvement activity accordingly
- Identifying whole-hospital trends
- Awareness raising of good record keeping at ward level/specialty

The audit findings will be presented at a number of hospital wide meetings, including the next Whole Hospital Audit Meeting, in December 2021. This will further raise awareness of the RCP Standards and the importance of good record keeping in order to generate improvements in compliance.

<u>Glangwili General Hospital</u>

The baseline audit involved 97 sets of records and it was a prospective audit. 10 sets of records were audited from across specialties.

From a review of the findings, the following areas for improvement at Glangwili General Hospital were identified:

Standard 2: Every page in the medical record should include the patient's name, identification number (NHS number) and location in the hospital	There was low compliance with this standard
Standard 5: Data recorded or communicated on admission, handover and discharge should be recorded using a standardised proforma	Not all specialties use admission proformas
Standard 6: Every entry in the medical record should be dated, timed (24 hour clock), legible and signed by the person making the entry. The name and designation of the person making the entry should be legibly printed against their signature. Deletions and alterations should be countersigned, dated and timed	Whilst there were few deletions/alterations made within the records audited, compliance with the standard was generally low and needs further investigation

The following site level improvement actions have been planned:

- Identifying differences across wards and targeting improvement activity accordingly.
- Identifying whole-hospital trends and variation in results and practice across sites.
- Awareness raising of good record keeping at ward level/specialty.

Additionally, further points noted for Glangwili General Hospital included:

- Individually, the Trauma and Orthopaedics department has started dictation of Consultant ward rounds. This has significantly improved record keeping and is a cost effective foothold into digital note taking;
- Paper used for note taking must be headed on both sides;
- Medical, Surgical and Trauma and Orthopaedics proformas would benefit from more prompts in order to encourage use of patient stickers.
- The Urology Team would greatly benefit from the use of a proforma to improve record keeping

And further potential improvements in the areas of:

- Definitively electronic note keeping will improve all aspects of record keeping;
- Use of Microsoft Teams ensures that date and time is recorded and is another strategy in place in the Health Board that will push towards electronic record keeping

<u>Withybush General Hospital</u>

A further snap-shot audit was proposed to be completed within Withybush Hospital within six months of the 2020 audit, to demonstrate the impact of quality improvement activity on site. However, following the previous update in October 2020, the second wave of the pandemic and subsequent recovery period has significantly impacted on the ability to progress actions at site level. It has been decided that it is not timely to re-audit at this point.

This delay does, however, present the opportunity to progress local and Health Board actions across sites within the same timeframe, given that baseline audits have now taken place on each site.

Health Board-wide Recommendations

A number of Health Board-wide recommendations have been identified and each site, through the leadership of the QI Site Lead, is committed to contributing towards achieving the following:

- Promotion of a Good Record Keeping Practice for Clinicians – RCP Standards module (to be made available on ESR), when available. Include in Doctors' induction;
- Aide memoires on good record keeping practices – posters, business cards;
- Potential roll out of stamps for clinicians, nursing staff and AHPs, with clinician's name, GMC number and space for date/time and initials;
- Future digitalisation of medical records.

It is important to note that considerable variation emerged in the findings for certain Standards, which may have resulted from interpretation of the audit questions. This will be reviewed in conjunction with the Clinical Audit Team and attempts made to resolve for future rounds of audit.

Structure for reporting Audit Outcomes

Due to the impact of the second wave of the pandemic, attendance at all of the Quality and Governance Groups, which would provide the opportunity to raise the RCP Record Keeping Audits under the Effective Clinical Practice item on the standardised agendas, has yet to be secured across all Directorates and Counties. Future discussion will take place through these meetings and will also provide the opportunity for issues to be escalated to Operational Quality, Safety and Experience Sub-Committee (OQSESC) and Quality, Safety and Experience Committee (QSEC) where necessary.

The local Audit findings have, however, been presented at the Whole Hospital Audit Meetings in Withybush General Hospital (March 2021) and Glangwili General Hospital (June 2021), and are due to be presented at the Whole Hospital Audit Meetings in Bronglais General Hospital and Prince Philip Hospital (December 2021). Future Health Board wide audits undertaken can be presented at the Health-Board wide Whole Hospital Audit Meetings.

In the meantime, the RCP Record Keeping Audit will be an annual inclusion on the formal Clinical Audit Programme and discussed at the Health Board's Clinical Audit Scrutiny Panel, with an opportunity to escalate via the Effective Clinical Practice Advisory Panel.

Update to the Clinical Record Keeping Policy

A Clinical Record Keeping Policy Steering Group has been convened, which is Chaired by the Assistant Medical Director for Quality and Safety. The Steering Group has clinical representation from medicine, surgery, nursing, midwifery, therapies, mental health and learning disabilities. A number of corporate services are also represented, including medical records, clinical coding, informatics, legal, complaints, information governance and equality and diversity.

The Group has met four times and has agreed its terms of reference, with the purpose of the Group being to agree a set of underpinning principles for record keeping, based on professional practice, which will be applicable across the Health Board and captured in a single generic clinical record keeping policy.

It is not anticipated that the development of the Clinical Record Keeping Policy alone will address the challenges associated with medical record keeping, however the Policy will emphasise the expected standards and provide a basis for communication, education and training activities.

The group has undertaken initial scoping to ensure that all existing Clinical Record keeping policies are considered within the remit of the project; and that the current standards for record keeping which are defined by professional bodies are considered.

The Group is striving towards the development of a single Clinical Record Keeping Policy, which contains a set of key principles for record keeping, informed by professional practice of the respective clinical groups. This policy would then signpost to more detailed record keeping practices that are required at professional/service level. Other areas of focus include the content of good medical records and improving the legibility of records.

Following a mapping exercise of a wide range of professional body principles for record keeping, a sub-group has been formed to progress the identification of key principles for good record keeping. This sub-group has met and commenced a detailed exercise to identify overarching principles, referring to the principles set out in existing policies, and cross-referencing with the professional body principles.

It is anticipated that the overarching principles will relate to all contributions to the medical record, and will therefore also be applicable to non-medical staff who contribute to health records.

Once the principles are agreed, there is scope to consider a Health Board developed audit tool, which would support audit against the agreed principles for record keeping.

Provisions for exploring a digitalised system in future

Members of the Clinical Record Keeping Policy Steering Group have been co-opted to the Clinical Informatics Group, and vice versa, to ensure that opportunities for digitalisation are reflected in the developing Clinical Record Keeping Policy, but that the work of the Steering Group does not duplicate. Updates from the Clinical Informatics Group discussion are regularly reported at the Clinical Record Keeping Policy Steering Group meetings.

There is a need to ensure that any overarching principles agreed for good record keeping can be met within a digitalised system.

Development of an e-learning module – Good Record Keeping Practice for Clinicians – RCP Standards

Work has taken place to develop the content of an e-learning module for Good Record Keeping Practice for Clinicians. However, as this was based on the RCP Standards, and a decision has been made to develop an overarching policy for all clinical areas, the e-module will be dependent upon the principles that are agreed by the Clinical Record Keeping Policy Steering Group, and which are formulated into the Clinical Record Keeping Policy.

Once the updated Clinical Record Keeping Policy has been developed, discussions will be recommenced with the Leadership Education Development Department regarding the translation of this course into an e-learning module, to be made available on ESR, including exploring the possibility of designating this a mandatory e-learning course.

There will also then be an opportunity to explore options to designate the e-learning and any other record keeping training courses as recognised Continuing Professional Development.

The Health Board has approached Swansea University to explore the possibility of extending the current 'good documentation' training, which is commissioned for nursing staff. This is a very well received training course, which is delivered approximately every two months. The scope of these discussions would include feasibility of delivering interprofessional training, on the basis of the agreed overarching principles for record keeping, which are being developed by the Clinical Record Keeping Policy Steering Group.

Stamps

Stamps have been rolled out to the Obstetrics and Gynaecology service and usage has commenced. Unfortunately, due to staffing constraints in the middle grade and consultant rota, there is not sufficient capacity within the service to progress an audit at present. It is anticipated that the service will be back to full complement by January 2022, at which point the audit can be commenced.

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is requested to receive this report as a source of assurance regarding the progress made in relation to the original Internal Audit report recommendations, and subsequent actions agreed by the Record Keeping Audit Working Group, following the delayed progress previously noted due to the pandemic response.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference Cyfeirnod Cylch Gorchwyl y Pwyllgor	2.1 The purpose of the Audit and Risk Assurance Committee is to advise and assure the Board and the Accountable Officer on whether effective arrangements are in place, through the design and operation of the UHB's system of assurance, to support them in their decision taking and in discharging their accountabilities for securing the achievement of the UHB's objectives, in accordance with the standards of good governance determined for the NHS in Wales. 2.2 The Committee independently monitors, reviews and reports to the Board on the processes of governance, and where appropriate, facilitates and supports, through its independence, the attainment of effective processes. 2.3 Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	689 – RCP Medical Records Standards - Good medical record keeping Current Risk Score – 3x4=12
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2. Safe Care 3. Effective Care

Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2018-2019	4. Improve Population Health through prevention and early intervention, supporting people to live happy and healthy lives 8. Transform our communities through collaboration with people, communities and partners

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	RCP Record Keeping Standards Internal Audit Report October 2018, RCP Medical Records Standards
Rhestr Termau: Glossary of Terms:	ESR – Electronic Staff Record
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg: Parties / Committees consulted prior to Audit and Risk Assurance Committee:	Clinical Record Keeping Policy Steering Group Clinical Audit Manager Head of Effective Clinical Practice and Quality Improvement Assistant Director, Medical Directorate

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	None
Ansawdd / Gofal Claf: Quality / Patient Care:	This recommendation will improve patient safety and care.
Gweithlu: Workforce:	None
Risg: Risk:	This recommendation is to mitigate risks highlighted in the Internal Audit, RCP Medical Record Keeping Standards report, October 2018, and historical issues with the standard of medical record keeping Medical Directorate Risk reference - 689
Cyfreithiol: Legal:	None
Enw Da: Reputational:	None
Gyfrinachedd: Privacy:	None
Cydraddoldeb: Equality:	No negative impacts. The recommendation will have a positive impact as it has the potential to improve the standard of care for all patients.

Appendix 1

Please see a summary of the audit result below, with the caveat that collation or comparison is not possible due to the differing methodologies and timeframes, as well as a need to review data collection and interpretation given the variance seen across some standards.

RCP Standard audited to: Average % score of all records		PPH Audit 2021	GGH Audit 2021	BGH Audit 2021	WGH Audit 2020
Standard 2:	No. of patients first and last name on each page	60.5%	52%	49%	57%
	No. of pages with patient's NHS number or other unique identifier	55.3%	46%	38%	60%
Standard 3:	Compliance with standardised structure of health record, following the organisational protocol	37.5%	100%	29%	80%
Standard 4:	Documentation reflecting continuum of patient care and in chronological order	92.5%	100%	80%	87%
Standard 5:	Initial assessment handover recorded on standardised proforma	12.5%	100%	73%	50%
	Discharge summary recorded on standardised proforma*	48.8%	100%	57%	50%
Standard 9:	Record of change of consultant recorded and dated	100%	100%	100%	86%
	Record of change of consultant time recorded	91.6%	80%	100%	66%
Standard 6:	Percentage of written entries that have the date recorded	93.2%	96%	97%	97%
	Percentage of written entries that have the time recorded	86.9%	73%	91%	80%
	Percentage of written entries that have a signature	90.4%	93%	87%	95%
	Percentage of written entries that have a legible printed name recorded	74.5%	81%	78%	79%
	Percentage of written entries that have a legible printed designation recorded.	65%	68%	53%	67%
	Number of deletions / alterations	123	143	120	
	Percentage of deletions/alterations that are countersigned	3%	7%	12%	2%
	How many deletions/alterations were dated?	20%	9%	2	0%
	How many deletions/alterations had the time recorded?	15.4%	0%	3	0%
Standard 8:	How many written entries indicate the responsible lead professional was present?	46.5%	90%	78%	64%
Standard 10:	Identified time period gaps between entries in patient's record **	4.3%	3	2	1
	Where there is an identified gap, an explanation has been provided?	94%	0%	0	0%

Standard 12:	Decision of ‘DNR’ recorded clearly	**29.6%**	**100%**	**55%**	**67%**
	Decision of ‘DNR’ recorded clearly with decision maker clearly identified ***	**45.5%**	**100%**	**41%**	**65%**
	No of health records audited	**80**	**97**	**60**	**92**